Amendment 1

Attached to and made a part of the Master Services Agreement MSA-141890

an agreement between

Aetna Life Insurance Company

(hereinafter referred to as Aetna)

and the Customer

AFFILIATED PHYSICIANS AND EMPLOYERS MASTER TRUST

Nothing contained in this amendment shall be held to alter or affect any of the terms of the Services Agreement other than as herein specifically stated.

It is understood and agreed that the following Schedules and Addendums, as attached, are added to the list of Schedules in Schedule 18 (J), Entire Agreement; Order of Priority, and thereby become part of the Services Agreement.

- Pharmacy Services and Fee Schedule
- Prescription Drug Services Schedule
- Pharmacy Addendum
- Pharmacy Performance Guarantees Addendum

The Services Agreement is not changed in any other respects.
In Witness Whereof, the parties have signed this amendment to become effective January 1, 2021.

AETNA LIFE INSURANCE COMPANY

By: Daniel J. Loftus

Name: Daniel J. Loftus

Title: Contract Lead

Date: October 27, 2020

AFFILIATED PHYSICIANS AND EMPLOYERS MASTER TRUST

By: _____

Name: _____

Title: _____

Date: _____

PHARMACY
SERVICE AND FEE SCHEDULE
MSA – 141890
EFFECTIVE January 1, 2021 ("Schedule Effective Date")

AETNA PBM SERVICES FEE SCHEDULE – CORE SERVICES

Unless otherwise specified, the services outlined below are Included at no additional cost for APEMT and its Members.

PBM Services	
Included in Core Services	
PBM Benefit Administration	**Member Services**
• Maintenance Choice	• Member Services Call Center – Available 24/7
• Aetna Standard Preventive Drug List (HDHP)	• Real-Time Benefits
• Aetna Standard Preventive Drug List (ACA)	• Aetna Health Mobile App and Internet Tools
• Integrated retail, mail and specialty claims with medical benefit claims in real-time	• Price-A-Drug Tool available at **aetna.com** or through our mobile app, Aetna Health
• Generic substitution/DAW penalties	• ExtraCare Health Card with discounts at CVS
Member Communication Materials	**Customer Services**
• Implementation benefits communication materials, printed and online support	• Claim funding and banking arrangements integrated with your Aetna medical plan
• Member specific e-mail communications	• Consultative services
• Aetna Integrated Pre- and Post-enrollment materials	• Education materials on key healthcare topics
• Clinical program member letters, including transition letters for formulary changes/updates	• Implementation support including eligibility loading and ongoing additions/deletions
• Informational brochures for using the CVS Caremark Mail Service Pharmacy, including order forms	• Regulatory and compliance support by specific line of business
• Member-specific formulary and plan design	• Meetings to discuss program performance
• Aetna Health website and app brochures	• Pharmacy account team and clinical support
Claims Processing Services	**Mail Service Pharmacy**
• Online, point of service claims processing and clinical edits included with our traditional pricing model	• Access to the CVS Caremark Mail Service Pharmacies Network
Specialty Pharmacy	• Profile/order form and return envelope
• Use of CVS Specialty Pharmacies	• Member counseling labels – drug specific
• Specialty copay plan designs	• First time fill prescription processing

Analytics and Reporting	
Included in Core Services	
Analytic Support	**Analytic Support cont.**
• Aetna Report Rx self-service reporting tool suite for up to 10 Customer users	• Claim detail reporting combined with medical reporting through the new reporting tool, ART

[redacted]

Included in Core Services
[redacted]

AETNA PBM SERVICES FEE SCHEDULE – ADDITIONAL SERVICES

aetna™

[redacted]

[redacted]

Charges for services not identified above and/or changes in financial terms resulting from a change in the scope of services shall be quoted upon request.

Pricing noted above for programs not implemented within twelve (12) months from the time of pricing negotiations is subject to change.

NOTES:

[1] Pharmacy Advisor Additional Terms:

(a) Customer may terminate the Pharmacy Advisor program by providing Aetna at least sixty (60) days prior written notice.

(b) The pricing described above for Pharmacy Advisor is based on the following conditions:

(i) In the event Customer desires to include additional lines of business, implement a portion of the Plan Participants, or reduces the Plan Participants participating in the Pharmacy Advisor program, Aetna may revise pricing for the program.

(ii) Customer agrees to implement all of the current conditions in Pharmacy Advisor Counseling: Asthma/COPD, Breast Cancer, Depression, Diabetes, Cardiovascular conditions, and Osteoporosis.

(iii) The above pricing reflects the current program and future program expansions may require an additional fee.

(b) For Pharmacy Advisor Counseling at CVS Pharmacy, Aetna guarantees that the aggregate gross savings realized from the Pharmacy Advisor Counseling Program services over the Clinical Program Term shall be [redacted] of the aggregate fees paid by Customer for the Clinical Program Term. For the purpose of this guarantee, the term "Clinical Program Term" means the [redacted] period following implementation of the Pharmacy Advisor Counseling Program.

This ROI is contingent upon Customer providing Aetna with (a) the required prior year Plan Participant, Eligibility and Prescription data elements prior to calculation of the ROI if Aetna was not Customer's PBM in the calendar year prior to Customer's implementation of the Pharmacy Advisor Counseling Program; and (b) sufficient and accurate eligibility information, which includes Plan Participant current telephone numbers.

The ROI savings calculation shall be determined as follows:

1. Medication Possession Ratio – If a Plan Participant's Medication Possession Ratio is equal to or greater than [redacted] (i.e., the member is "optimally adherent") then the associated savings, which may include productivity savings, for each Plan Participant who is optimally adherent will be credited to the ROI guarantee based on the condition-specific savings identified in current peer reviewed clinical literature; and
2. Gaps in therapy closure – For each gap in therapy closed, (i.e. a first fill of a recommended drug) Aetna will include the associated savings in its ROI guarantee.

Customer acknowledges and agrees that the estimated health care savings described above in paragraph 1 and 2, reflect an estimate of the healthcare costs presumed to be avoided through the actions of Aetna to improve medication adherence and close gaps in care associated with certain chronic conditions that typically have high levels of medical costs. This amount will be an estimate of the healthcare costs avoided by the Plan through the associated condition-specific savings identified in current peer reviewed clinical literature.

Aetna reserves the right to revise the ROI in the event of changes to Plan design or Plan Participant population that materially impacts the effectiveness of the Pharmacy Advisor Counseling Program. Customer acknowledges it shall not be eligible to receive an ROI savings guarantee under any other program, which includes adherence or closing gaps in therapy, with the exception of Condition Alerts, during any period that Customer receives an ROI savings guarantee under the Pharmacy Advisor Counseling Program. In the event Aetna fails to meet the ROI guarantee, [redacted]

[2] Drug Savings Review Additional Terms:

Aetna guarantees that the gross savings realized from these services over the Clinical Program Year of the Agreement for the Drug Savings Review Program shall be [redacted] of the expense to Customer for these services over the Clinical Program Year. In the event Aetna fails to meet the targeted savings, [redacted] "Clinical Program Year" means the twelve (12) month period commencing on the start date of the Drug Savings Review Program and each full consecutive twelve (12) month period thereafter that the Drug Savings Review Program is provided.

[3] Health Advisor Additional Terms:

ROI description

***DEFINITIONS:**

PMPM = Per Member Per Month

AETNA PBM SERVICES FEE SCHEDULE – THIRD-PARTY SERVICES

The services outlined below are provided by third party providers.

[redacted]

PRESCRIPTION DRUG SERVICES SCHEDULE
MASTER SERVICES AGREEMENT MSA- 141890
Effective January 1, 2021 ("Schedule Effective Date")

Subject to the terms and conditions of the Agreement, the Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by the Customer in the Prescription Drug Service and Fee Schedule (as modified by Aetna from time to time pursuant to section 4, Service Fees, of the Agreement) will be provided or arranged by Aetna through its affiliate, CVS Caremark. Additional Services may be provided at the Customer's written request under the terms of the Agreement. This Schedule shall supersede any previous document(s) describing the Services.

I. SCHEDULE TERM

The initial term of this Schedule shall be three (3) years beginning on the Schedule Effective Date (referred to as an "Agreement Period"). This Schedule will automatically renew for additional Agreement Periods (successive one (1) year terms) unless otherwise terminated pursuant to the Agreement.

II. CLAIM FIDUCIARY

The Customer and Aetna agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974, as amended, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. The Customer understands that the performance of fiduciary duties under ERISA necessarily involves the exercise of discretion on Aetna's part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Therefore, and to the extent not already implied as a matter of law, the Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan. It is also agreed that, as between the Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.

III. EXTERNAL REVIEW

The external review process will be conducted by an independent clinical reviewer with appropriate expertise in the area in question. External Review shall be available for certain "Adverse Benefit Determinations" as defined in 29 CFR 2560.503-1 as amended by 26 CFR 54.9815-2719. It shall also be available for eligible "Final Internal Adverse Benefit Determinations", which is an eligible Adverse Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal review process or an Adverse Benefit Determination for which the appeal process has been exhausted. The External Review process shall meet the standards of the Federal Affordable Care Act and utilize a minimum of three accredited Independent Review Organizations. Independent reviewers conduct a de novo review of the information provided to them as part of the External Review process. Both Aetna and Customer acknowledge that neither Plan Participants nor providers will be penalized for exercising their right to an External Review.

The Customer delegates the sole discretionary authority to make the determination regarding the eligibility for external review, under the Plan, to Aetna. If an appeal is denied through the final level of internal appeal,

Aetna will determine if it is eligible for ERO. Then Aetna will inform the Plan Participant of the right to appeal through ERO. If the appeal is upheld, Aetna will inform the Plan Participant the reason for the denial. If the appeal is not eligible for ERO, Aetna will inform the Plan Participant of the reasons for the ineligibility.

The Customer acknowledges that the Independent Review Organizations that make the external review decisions are independent contractors and not agents or employees of Aetna, and that Aetna is not responsible for the decision of the Independent Review Organization.

To assist in conducting such external reviews, the Customer agrees to provide Aetna with the current Plan documents, and any revised, amended, or updated versions no later than the date of any revisions, amendments, or updates.

IV. DEFINITIONS

When used in this Schedule and/or the Prescription Drug Service and Fee Schedule, all capitalized terms shall have the following meanings if not already defined in the Agreement:

"Average Wholesale Price" or **"AWP"** means the "average wholesale price" for a Covered Service based on the most current pricing information published by Medi-Span for the date and time the Covered Service is dispensed by the Pharmacy. The AWP of a Covered Service will be the AWP unit price as published by Medi-Span for the eleven (11) digit NDC. PBM shall not allow adjudication of NDCs of licensed re-packagers where the data source identifies the licensed re-packagers AWP is greater than the original pharmaceutical AWP.

"Benefit Cost(s)" means the cost of providing Covered Services to Plan Participants and includes amounts paid to Participating Pharmacies and other providers. Benefit Costs do not include Cost Share amounts paid by Plan Participants. Benefit Costs do not include Service Fees. The Benefit Cost includes any Dispensing Fee paid to a Participating Pharmacy or other provider for dispensing covered medications to Plan Participants.

"Benefit Plan Design" means the terms, scope and conditions for Prescription Drug or device benefits under a Plan, including Formularies, exclusions, days or supply limitations, prior authorization or similar requirements, applicable Cost Share, benefit maximums and any other features or specifications as may be included in Plan documents, as communicated by the Customer to Aetna in accordance with any implementation procedures described herein. The Customer shall disclose to Plan Participants any and all matters relating to the Benefit Plan Design that are required by law to be disclosed, including information relating to the calculation of Cost Share or any other amounts that are payable by a Plan Participant in connection with the Benefit Plan Design.

"Biosimilar Drug" means a type of biological product that is licensed (i.e., approved) by the Food and Drug Administration (FDA) because the product is highly similar to an already FDA-approved biological product, known as the reference product, and has been shown to have no clinically meaningful differences from the reference product. For purposes of this Agreement and this definition, a Biosimilar Drug also shall include an "interchangeable biological product" which, in addition to meeting the biosimilar standard, is expected to produce the same clinical result as the reference product in any given patient. Biosimilar Drugs are determined by the FDA from time to time and listed in the FDA's Purple Book (presently found at: http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicApplications/Biosimilars/ucm411418.htm) Biosimilar Drugs are Brand Drugs.

"Brand Drug" means a Covered Product that is defined by Medi-Span as a "M", "N", "O", with exception of Authorized Generics as defined in this RFP. The Parties agree that when a drug is classified as a Brand Drug, it shall be considered a Brand Drug for all purposes under the Agreement, including adjudication, therapeutic classification, pricing and all related guarantees.

"Calculated Ingredient Cost" means the lesser of:

a) AWP less the applicable percentage Discount;
b) MAC; or
c) U&C Price.

The Calculated Ingredient Cost does not include the Dispensing Fee or sales tax, if any. The amount of the Calculated Ingredient Cost payable by the Customer is net of the applicable Cost Share.

"Claim" or **"Claims"** means any electronic or paper request for payment or reimbursement arising from a Participating Pharmacy providing Covered Services to a Plan Participant.

"Compound" means a Prescription where two or more solid, semi-solid, or liquid medications are mixed together. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring, or sodium chloride solutions are added.

Compound Prescription" means a Prescription Drug which would require the dispensing pharmacist to produce an extemporaneously produced mixture containing at least one Federal Legend drug, the end product of which is not available in an equivalent commercial form. For purposes of this Schedule, a prescription will not be considered a Compound Drug if it is reconstituted or if the only ingredient added to the prescription is water, alcohol, a sodium chloride solution or other common dilatants.

For purposes of adjudicated Compound Prescription Drugs, the invoicing Participating Pharmacy will submit to Aetna the following for each Compound Prescription Drug dispended thereby: (a) compound indicator; (b) eleven-digit NDC, quantity, and submitted ingredient cost for each component in the Compound Prescription Drug recipe; (c) total quantity and total Usual & Customary price; and (d) level of effort value. Aetna will determine the appropriate ingredient cost, or NDC, for each component using the lower of (1) the AWP discount; (2) MAC; or (3) the submitted ingredient cost. The level of effort charge will be applied in addition to the appropriate Dispensing Fee.

"Concurrent Drug Utilization Review" or **"Concurrent DUR"** means the review of drug utilization when an On-Line Claim is processed by Aetna at the point of sale.

"**Cost Share"** means that portion of the charge for a Prescription Drug or device dispensed to a Plan Participant that is the responsibility of the Plan Participant as provided in the applicable Plan, including coinsurance, copayments, deductibles and penalties, and may be a fixed amount or a percentage of an applicable amount. Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services except as required by law to be otherwise.

"Covered Services" means Prescription Drugs, Specialty Products, over-the-counter medications or other services or supplies that are covered under the terms and conditions set forth in the description of the Plan.

"Discount" means the percentage deduction from AWP that is to be taken into account by Aetna in determining the Calculated Ingredient Cost.

"Dispensing Fee" means the service fee or amount payable to a pharmacy to cover the cost of dispensing a Covered Service. The Dispensing Fee is added to the discounted AWP or MAC. No Dispensing Fee is added to the U&C.

"DMR Claim" means a direct member (Plan Participant) reimbursement claim.

"Formulary" or **"Formularies"** means the list(s) of Prescription Drugs and supplies approved by the U.S. Food and Drug Administration ("FDA") developed by Aetna which classifies drugs and supplies for purposes of benefit design and coverage decisions.

"Generic Drug" means a drug as defined by MediSpan as a "Y". Generic Drugs also shall include Brand Drugs that are treated as "house" generic drugs (Dispense As Written [DAW5]) by the Participating Network Pharmacy, Single Source Generic Drugs, and Authorized Generics.. The Parties agree that when a drug is classified as a Generic Drug, it shall be considered a Generic Drug for all purposes under the Agreement, including adjudication, therapeutic classification, pricing and all related guarantees.

"House or Authorized Generic Drug" means a Brand Drug submitted with a DAW 5 in place of its generic equivalent and where the pharmacy is reimbursed at a Generic Drug rate, including MAC, as applicable. For reconciliation of the mail Generic Drug discount guarantees, the AWP of house generics shall be the average per unit AWP of the generic equivalents, and not the AWP of the Brand Drug.

"Implementation Credit" if applicable, is a credit provided to the Customer to cover specific costs related to the transition from another vendor to Aetna and further described in the Fee Schedule

Limited distribution drugs (LDDs) and exclusive distribution drugs

Limited distribution and exclusive distribution Specialty Products are only available through a limited number of pharmacy providers due to exclusive or preferred vendor arrangements with drug manufacturers.

"Mail Order Pharmacy" or **"Specialty Pharmacy"** means a licensed mail order and specialty pharmacy designated by Aetna to provide or arrange for Covered Services to Plan Participants.

"Maximum Allowable Cost" or **"MAC"** means the cost basis for reimbursement established by Aetna, as modified from time to time, for the same dose and form of Generic Drugs which are included on Aetna's applicable MAC List.

"MAC List(s)" means the lists of MAC payment schedules for Prescription Drugs, devices and supplies identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case the Brand Drug may also be on the MAC List) and developed and maintained or selected by Aetna and that, in each case, are deemed to require or are otherwise capable of pricing management due to the number of drug manufacturers, utilization and/or pricing volatility.

"National Drug Code" or **"NDC"** means a universal product identifier for human drugs. The National Drug Code Query (NDCQ) content is limited to Prescription Drugs and a few selected OTC products. The National Drug Code (NDC) Number is a unique, eleven-digit, three-segment number that identifies the labeler/vendor, product, and trade package size. **"NDC-11"** means the full National Drug Code.

"On-Line Claim" means a claim that (i) meets all applicable requirements, is submitted in the proper timeframe and format, and contains all necessary information, and (ii) is submitted electronically for payment to Aetna by a Participating Pharmacy as a result of provision of Covered Services to a Plan Participant.

"Participating Pharmacy" means a Participating Retail Pharmacy, Mail Order Pharmacy or Specialty Pharmacy.

"Participating Retail Pharmacy" means any licensed retail pharmacy that has entered into an arrangement with Aetna to provide Covered Services to Plan Participants.

"**Prescription Drug Service and Fee Schedule**" means a document entitled same and incorporated herein by reference setting forth certain guarantees (if applicable), underlying conditions and other financial information relevant to Customer.

"Precertification" means a process under which certain drugs require precertification (prior approval) before Plan Participants can obtain them as a covered benefit. Aetna's Precertification unit must receive prior notification from physicians or their authorized agents requesting coverage for medications on the Precertification List.

"Prescriber" means an individual who is appropriately licensed and permitted by law to order drugs that legally require a prescription.

"Prescription Drug" means a legend drug that, by law, cannot be sold without a written prescription from an authorized Prescriber. For purposes of this Schedule, insulin, certain supplies, and devices shall be considered a Prescription Drug.

"Prospective Drug Utilization Review" or **"Prospective DUR"** means a review of drug utilization that is performed before a prescribed medication is covered under a Plan.

[redacted]

"Rebate Guarantee" means the Rebate amount that Aetna guarantees the Customer will receive as set forth in the Prescription Drug Service and Fee Schedule.

"Retrospective Drug Utilization Review" or **"Retrospective DUR"** means a review of drug utilization that is performed after a Claim for Covered Services is processed.

"Single Source Generic Drugs" means those Generic Drugs that are provided by only one manufacturer, including generics with limited availability, exclusivity, or competition, including Authorized Generics. When a drug is identified as Single Source Generic Drug, it shall be considered a Generic Drug for all purposes under this Agreement, including adjudication, therapeutic classification, pricing, and all guarantees.

"Specialty Product" means a Covered Service that: (a) is injected, infused, orally or topically administered, or inhaled for the ongoing treatment of complex, chronic conditions; (b) requires extensive patient education, risk assessment, mitigation strategies, and/or clinical monitoring; (c) may require temperature-controlled shipping or other special handling and careful adherence to treatment; and (d) meets CMS Requirements for placement on the Specialty Tier in a Medicare Formulary, if applicable. A Covered Service determined by Aetna to be a Specialty Product under the Agreement will be considered a Specialty Product for all purposes under the Agreement, including for purposes of adjudication, therapeutic classification, pricing, Rebates, and guarantees.

"Step-Therapy" means a type of Precertification under which certain medications will be excluded from coverage unless the Plan Participant tries one or more "prerequisite" drug(s) first, or unless a medical exception for coverage is obtained.

"Usual and Customary Retail Price" or **"U&C Price"** means the cash price less all applicable Customer discounts which Participating Pharmacy usually charges customers for providing pharmaceutical services.

"Wholesale Acquisition Cost" or **"WAC"** means the wholesale acquisition cost of a prescription drug as listed in the Medi-Span weekly price updates (or any other similar publication designated by Aetna) received by Aetna.

V. ADMINISTRATIVE SERVICES

Subject to the terms and conditions of this Schedule, the Services to be provided by Aetna, as well as certain Customer obligations in connection thereto, are described below.

1. General Responsibilities and Obligations

a. Exclusivity

During the term of this Schedule, the Customer shall use Aetna as the exclusive provider of the Benefit Plan Design for Plan Participants covered thereby, including without limitation, for pharmacy claims processing, pharmacy network management, clinical programs, formulary management and rebate management. All terms under this Schedule and on the attached Prescription Drug Service and Fee Schedule are conditioned on Aetna's status as the exclusive provider of the Benefit Plan Design. Any failure by the Customer to comply with this Section shall constitute a material breach of this Schedule and the Agreement. Without limiting Aetna's other rights or remedies, in the event the Customer fails to comply with this section, Aetna shall have the right to modify the terms and

conditions of this Schedule, including without limitation, the financial terms set forth in the Prescription Drug Service and Fee Schedule and any Performance Guarantees attached hereto.

This exclusively arrangement applies for lives for which Aetna's offering was established. Aetna agrees to waive the exclusively requirement for new groups or lives that were not part of the original offering.

2. Pharmacy Benefit Management Services

a. Pharmacy Claims Processing

(i) On-Line Claims Processing. Aetna will perform claims processing services for Covered Services that are provided by a Participating Pharmacy after the Effective Date, and submitted electronically to Aetna's on-line claims processing system. On-Line Claim processing services shall include confirmation of coverage, performance of drug utilization review activities pursuant to this Schedule, determination of Covered Services, and adjudication of the On-Line Claims.

(ii) DMR Claims Processing. The Plan Participant shall be responsible for the submission of DMR Claims directly to Aetna on such form(s) provided by Aetna within the timeframe specified on the description of Plan benefits. DMR Claims shall be reimbursed by Aetna based on the lesser of: (i) the amount invoiced and indicated on such DMR Claim; or (ii) the amount the Plan Participant is entitled to be reimbursed for such claim pursuant to the description of Plan benefits.

b. Pharmacy Network Management

(i) Participating Retail Pharmacies. Any additions or deletions to the network of Participating Retail Pharmacies shall be made in Aetna's sole discretion. Aetna shall provide notice to the Customer of any deletions that have a material adverse impact on Plan Participants' access to Participating Retail Pharmacies. Aetna shall direct each Participating Retail Pharmacy to (a) verify the Plan Participant's eligibility using Aetna's on-line claims system, and (b) charge and collect the applicable Cost Share from Plan Participants for each Covered Service. Aetna will adjudicate On-Line Claims for Covered Services from Participating Retail Pharmacies using the negotiated rates that Aetna has in place with the applicable Participating Retail Pharmacy.

- Aetna shall require each Participating Retail Pharmacy to comply with Aetna's applicable network participation requirements. Aetna does not direct or otherwise exercise any control over the professional judgment exercised by any pharmacist dispensing prescriptions or providing pharmacy services. Participating Retail Pharmacies are independent contractors of Aetna and Aetna shall have no liability to the Customer, any Plan Participant or any other person or entity for any act or omission of a Participating Retail Pharmacy or its agents, employees or representatives.

- Aetna shall adjudicate each On-Line Claim for services rendered by a Participating Retail Pharmacy at the applicable Discount and Dispensing Fee negotiated between Aetna and the Customer. For the avoidance of doubt, the Benefit Cost paid by the Customer in connection with On-Line Claims for services rendered by Participating Retail Pharmacies may or may not

be equal to the Discount and Dispensing Fees negotiated between Aetna and such pharmacies. This is considered "traditional" or "lock in" pricing.

(ii) Mail Order Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Mail Order Pharmacy on its internet website and via its member services call center. The Mail Order Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Mail Order Pharmacy generally will require that medications and supplies be dispensed in quantities not to exceed a ninety (90) day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable law do not prohibit substitution of a Generic Drug equivalent, if any, for the prescribed drug, or if the Mail Order Pharmacy obtains consent of the Prescriber, the Mail Order Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. Certain Specialty Products, some acute drug products or certain compounds cannot be ordered through the Mail Order Pharmacy. The Mail Order Pharmacy shall make refill reminder and on-line ordering services available to Plan Participants. Aetna and/or the Mail Order Pharmacy may promote the use of the Mail Order Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Mail Order Pharmacy's cost, unless otherwise agreed upon by Aetna and the Customer.

(iii) Specialty Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Specialty Pharmacy on its internet website and via its member services call center. The Specialty Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Specialty Pharmacy generally will require that Specialty Products be dispensed in quantities not to exceed a 30-day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable law do not prohibit substitution of a Generic Drug equivalent, if any, to the prescribed drug, or if the Specialty Pharmacy obtains consent of the Prescriber, the Specialty Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. The Specialty Pharmacy shall make refill reminder services available to Plan Participants. Aetna and/or the Specialty Pharmacy may promote the use of the Specialty Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Specialty Pharmacy's cost, unless otherwise agreed upon by Aetna and the Customer. Further information regarding Specialty Product pricing and limitations is provided in the Service and Fee Schedule.

c. Clinical Programs (Please also refer to the "Services Fee Schedule")

(i) Formulary Management. Aetna offers several versions of formulary options ("Formulary") for the Customer to consider and adopt as its Formulary. The Formulary options made available to the Customer will be determined and communicated by Aetna prior to the implementation date. The Customer agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted the Customer the right to use one of its Formulary options during the term of the Agreement solely in connection with the plan, and to distribute or make the Formulary available to members. As such, the Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the plan. The Customer further understands and agrees that from time to time Aetna may propose modifications to the drugs and supplies included on the Formulary as a

result of factors, including but not limited to, market conditions, clinical information, cost, rebates and other factors. The Customer agrees that any proposed additions and/or deletions to the Formulary will be adopted by the plan sponsor as a matter of the plan sponsor's plan design, and that the Customer has the right to elect to not implement any such addition or deletion, which such election shall be considered a Customer change to the Formulary subject to Aetna's ability to operationally administer such election and, if so, Aetna's reservation of right to make appropriate and equitable financial changes resulting therefrom. The Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

(ii) Prospective Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan benefits the Prospective DUR program, which may include Precertification and Step-Therapy programs and other Aetna standard Prospective DUR programs, with respect to On-Line Claims. Under these programs, Plan Participants must meet standard Aetna clinical criteria before coverage of the Prescription Drugs included in the program will be authorized; provided, however, the Customer authorizes Aetna to approve coverage of drugs for uses that do not meet applicable clinical criteria in the event of complications, co-morbidities and other factors that are not specifically addressed in such criteria. Aetna shall perform exception reviews and authorize coverage overrides when appropriate for such programs, and other benefit exclusions and limitations. In performing such reviews, Aetna may rely solely on diagnosis and other information concerning the Plan Participant deemed credible and supplied to Aetna by the requesting provider, applicable clinical criteria and other information relevant or necessary to perform the review.

(iii) Concurrent Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan benefits its standard Concurrent DUR programs with respect to On-Line Claims. Aetna's Concurrent DUR programs help Participating Pharmacies to identify potential drug interactions, duplicate drug therapy and other circumstances where prescriptions may be clinically inappropriate for Plan Participants. Aetna's Concurrent DUR programs are educational programs that are based on available clinical literature. Aetna's Concurrent DUR programs are administered using information submitted to and available in Aetna's on-line claims system, as well as On-Line Claims information submitted by the Participating Pharmacy.

(iv) Retrospective Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan benefits its standard Retrospective DUR programs with respect to On-Line Claims. Aetna's Retrospective DUR programs are designed to help providers and Plan Participants identify circumstances where prescription drug therapy may be clinically inappropriate or other cost-effective drug alternatives may be available. Aetna's Retrospective DUR programs are educational programs and program results may be communicated to Plan Participants, providers and plan sponsors. Aetna's Retrospective DUR programs are administered using information submitted to and available in Aetna's On-Line Claims system, as well as On-Line Claims information submitted by the Participating Pharmacy.

(v) Drug Savings Review If purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule, Aetna shall administer the Drug Savings Review program. Drug Savings Review uses Retrospective DUR approach. Claims are systematically analyzed within 72 hours of adjudication, for possible physician outreach based on program algorithms. The specific

outreach programs are designed to promote quality, cost-effective care in accordance with accepted clinical guidelines through mailings or telephone calls to physicians.

Drug Savings Review will analyze Claims on a daily basis, identify potential opportunities for quality and cost improvements, and will notify physicians of those opportunities. The physician-based programs will identify:

- Certain medications that may duplicate each other's effect;
- Certain drug to drug interactions; and
- Prescriptions for a multiple daily dose when symptoms might be controlled with a once-daily dosing.

(vi) Pharmacy Advisor Program. Aetna shall implement and administer as specified in the description of Plan benefits the Pharmacy Advisor Program which focuses on improving adherence, reducing costs and closing gaps in care in targeted conditions where adherence is critical, such as diabetes, asthma and heart failure. Identifying members with such targeted conditions will enable the Pharmacy Advisor Program to alert and provide pharmacists at local Participating Retail Pharmacies with information that will be helpful in their treatment. Effective January 1, 2021, the Pharmacy Advisor Program will be available only if purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule.

(ix) Aetna Healthy Actions℠ Rx Savings. If purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule, the Aetna Healthy Actions Rx Savings program helps to reduce a Plan Participant's cost share for certain prescription drugs and can include outreach to Plan Participants and prescribing doctor to help promote adherence. It targets drugs for which compliance has been found to be most critical to realize cost savings for Plan Participants and plan sponsors. The targeted drugs treat certain chronic conditions such as diabetes, hypertension, and asthma.

(x) Choose Generics Program. If purchased by the Customer as indicated on the Fee Schedule, the Choose Generics Program is an option that encourages Plan Participants to receive Brand Drugs rather than their generic equivalent. Under this program, Plan Participants can choose to obtain the Brand Drug at a higher than normal cost (subject to the exceptions described in the paragraph immediately below). Such higher cost will be equal to the Cost Share for the Brand Drug plus the difference in the cost between the Brand Drug and its generic equivalent. The cost differential is not applied to the Plan Participant's deductible.

If no generic equivalent medication or corresponding MAC amount is available or the prescriber has written "dispense as written" on the prescription order, the cost differential described above is not applied to the higher cost. In some instances, a Brand Drug is not eligible for a corresponding MAC amount due to Formulary and/or Rebate contract requirements that prohibit application of "member pay the difference" logic or mandate minimum copay steerage levels. In other instances, a Brand Drug may not be eligible for a corresponding MAC amount due to supply and/or pricing considerations.

Disclaimer Regarding Clinical Programs. Aetna's clinical programs do not dictate or control providers' decisions regarding the treatment of care of Plan Participants. Aetna assumes no liability

from the Customer or any other person in connection with these programs, including the failure of a program to identify or prevent the use of drugs that result in injury to a Plan Participant.

d. Plan Participant Services and Programs

Internet services including the Secure Member Portal and Aetna Website.
Through the Secure Member Portal, Plan Participants have access to the Aetna website and Aetna Health mobile app. Plan Participants have access to the following:

- Estimating the cost of Prescription Drugs (Price a Drug[SM]).
- Prescription Comparison Tool – Compares the estimated cost of filling prescriptions at a Participating Retail Pharmacy to the Mail Order Pharmacy mail-order prescription service.
- Aetna Formulary – Available for Plan Participants who wish to review prescribed medications to verify if any additional coverage requirements apply.
- View drug alternatives for medications not on the Preferred Drug List.
- Claim information and EOBs.

Through the Aetna Pharmacy website, Plan Participants have access to the following:

- Find-A-Pharmacy – This service helps locate an Aetna participating chain or independent pharmacy on hundreds of medications and herbal remedies.
- Tips on drug safety and prevention of drug interactions.
- Answers to commonly asked questions about prescription drug benefits and access to educational videos.
- Preferred Drug List and Generic Substitution List.
- Step Therapy List.

e. Rebate Administration

(i) The Customer acknowledges that CVS Caremark contracts for its own account with pharmaceutical manufacturers to obtain Rebates attributable to the utilization of certain prescription products by Plan Participants who receive benefits from customers for whom Aetna provides pharmacy benefit management services. CVS Caremark may share these Rebates with Aetna. Subject to the terms and conditions set forth in this Schedule, including without limitation, Aetna may pay to the Customer, Rebates based on the utilization by Plan Participants of rebateable Prescription Drugs administered and paid through the Plan Participant's pharmacy benefits.

(ii) If the Customer is eligible to receive Rebates under this Schedule, the Customer acknowledges and agrees that Aetna shall retain the interest (if any) on, or the time value of, any Rebates received by Aetna prior to Aetna's payment of such Rebates to the Customer in accordance with this Schedule. Aetna may delay payment of Rebates to the Customer to allow for final adjustments or reconciliation of Service Fees or other amounts owed by the Customer upon termination of this Schedule.

(iii) If the Customer is eligible to receive a portion of Rebates under this Schedule, the Customer acknowledges and agrees that such eligibility under paragraphs a. and b. above shall be subject

to the Customer's and its affiliates', representatives' and agents' compliance with the terms of this Schedule, including without limitation, the following requirements:

- Election of, and compliance with, Aetna's Formulary;
- Adoption of and conformance to certain benefit plan design requirements related to the Formulary as described in Prescription Drug Service and Fee Schedule; and
- Compliance with other generally applicable requirements for participation in Aetna's rebate program, as communicated by Aetna to the Customer from time to time.

The Customer further acknowledges and agrees that if it is eligible to receive a portion of Rebates under this Schedule, such eligibility shall be subject to the condition that the Customer, its affiliates, representatives and agents do not contract directly or indirectly with any other person or entity for discounts, utilization limits, Rebates or other financial incentives on pharmaceutical products or formulary programs for Claims processed by Aetna pursuant to this Agreement, without the prior written consent of Aetna. Without limiting Aetna's right to other remedies, failure by the Customer to obtain Aetna's prior written consent in accordance with the immediately preceding sentence shall constitute a material breach of the Agreement, entitling Aetna to (a) suspend payment of Rebates hereunder and to renegotiate the terms and conditions of this Agreement, and/or (b) immediately withhold any Rebates earned by, but not yet paid to, the Customer as necessary to prevent duplicative Rebates on such drugs.

VI. IMPORTANT INFORMATION ABOUT THE PHARMACY BENEFIT MANAGEMENT SERVICES

1. The Customer acknowledges that CVS Caremark contracts for its own account with pharmaceutical manufacturers to obtain Prescription Drug Formulary Rebates directly attributable to the utilization of certain Prescription Drugs by Plan Participants who receive Covered Services. The Rebate amounts vary based on several factors, including the volume of utilization, benefit plan design, and Formulary or preferred coverage terms. CVS Caremark may share these rebates with Aetna. Aetna may offer the Customer an amount of Rebates on Prescription Drugs that are administered and paid through the Plan Participant's pharmacy benefit. These Rebates are earned when members use drugs listed on Aetna's Formulary and preferred Specialty Products. Aetna determines each customer's Rebates based on actual Plan Participant utilization of those Formulary and preferred Specialty Products for which Aetna also has manufacturer Rebate contracts. The amount of Rebates will be determined in accordance with the terms set forth in the Customer's Prescription Drug Service and Fee Schedule.

   Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit will be retained by Aetna as compensation for Aetna's efforts in administering the preferred Specialty Products program. Pharmaceutical rebates earned on Prescription Drugs and Specialty Products administered and paid through the Plan Participant's pharmacy benefits represent the great majority of Rebates.

   A report indicating the Plan's Rebate payments, broken down by calendar quarter, is included with each remittance received under the program, and is also available upon request. Remittances are distributed as outlined in the Prescription Drug Service and Fee Schedule. Interest (if any) received by Aetna prior to allocation to eligible self-funded customers is retained by Aetna.

Any material plan changes impacting administration, utilization or demographics may impact Rebate projections and actual Rebates received. Aetna reserves the right to terminate or change this program prior to the end of any Agreement Period for which it is offered if: (a) there is any legal, legislative or regulatory action that materially affects or could affect the manner in which Aetna conducts its Rebate program; (b) any material manufacturer Rebate contracts with Aetna are terminated or modified in whole or in part; or (c) the Rebates actually received under any material manufacturer Rebate contract are less than the level of Rebates assumed by Aetna for the applicable Agreement Period. If there is any legal action, law or regulation that prohibits, or could prohibit, the continuance of the Rebate program, or an existing law is interpreted to prohibit the program, the program shall terminate automatically as to the state or jurisdiction of such law or regulation on the effective date of such law, regulation or interpretation.

2. The Customer acknowledges that from time to time, Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Rebates and which are paid separately to Aetna or designated third parties (e.g., mailing vendors, printers). These payments are to reimburse Aetna for the cost of various educational programs. These programs are designed to reinforce Aetna's goals of maintaining access to quality, affordable health care for Plan Participants and the Customer. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. Aetna may also receive payments from Prescription Drug manufacturers and other organizations that are not Rebates. These payments are generally for one of three purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data, (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and Plan Participants about clinical guidelines, disease management and other effective therapies, or (iii) to compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder. These payments are not considered as Rebates and are not included in rebate sharing arrangements with plan sponsors, including without limitation, Customer.

   CVS Caremark may also receive network transmission fees from its network pharmacies for services it provides for them. These amounts are not considered rebates and are not shared with plan sponsors. These amounts are also not considered part of the calculation of claims expense for purposes of discount guarantees.

   Customer agrees that the amounts described above are not compensation for services provided under this Agreement by either Aetna or CVS Caremark, and instead are received by Aetna or CVS Caremark in connection with network contracting, provider education and other activities Aetna conducts across its book of business. Customer further agree that the amounts described above belong exclusively to Aetna or CVS Caremark, and Customer has no right to, or legal interest in, any portion of the aforesaid amounts received by Aetna or CVS Caremark.

   These other payments are unrelated to the Prescription Drug Formulary Rebate arrangements and serve educational as well as other functions. Consequently, these payments are not considered Rebates, and are not included in the Rebates provided to the Customer, if any.

3. The Customer acknowledges that in evaluating clinically and therapeutically similar Prescription Drugs for selection for the Formulary, Aetna reviews the costs of Prescription Drugs and takes into account Rebates negotiated between Aetna and Prescription Drug manufacturers. Consequently, a Prescription

Drug may be included on the Formulary that is more expensive than a non-Formulary alternative before any Rebates Aetna may receive from a Prescription Drug manufacturer are taken into account. In addition, certain Prescription Drugs may be chosen for Formulary status because of their clinical or therapeutic advantages or level of acceptance among physicians even though they cost more than non-Formulary alternatives. The net cost to the Customer for Covered Services will vary based on: (i) the terms of Aetna's arrangements with Participating Pharmacies; (ii) the amount of the Cost Share obligation under the terms of the Plan; and (iii) the amount, if any, of Rebates to which the Customer is entitled under this Schedule and Prescription Drug Service and Fee Schedule. As a result, the Customer's actual claim expense per prescription for a particular Formulary Prescription Drug may in some circumstances be higher than for a non-Formulary alternative.

In Plans with Cost Share tiers, use of Formulary Prescription Drugs generally will result in lower costs to Plan Participants. However, where the Plan utilizes a Cost Share calculated on a percentage basis, there could be some circumstances in which a Formulary Prescription Drug would cost the Plan Participant more than a non-Formulary Prescription Drug because: (i) the negotiated Participating Pharmacy payment rate for the Formulary Prescription Drug may be more than the negotiated Participating Pharmacy payment rate for the non-Formulary Prescription Drug; and (ii) Rebates received by Aetna from Prescription Drug manufacturers are not reflected in the cost of a Prescription Drug obtained by a Plan Participant.

4. The Customer acknowledges that Aetna contracts with Participating Retail Pharmacies through CVS Caremark to provide the Customer and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna or CVS Caremark to Participating Retail Pharmacies vary among Participating Retail Pharmacies in Aetna's network, and can vary from one pharmacy product, plan or network to another. Under this Schedule and Prescription Drug Service and Fee Schedule, the Customer and Aetna have negotiated and agreed upon a uniform or "lock-in" price to be paid by the Customer for all claims for Covered Services dispensed by Participating Retail Pharmacies. This uniform price may exceed or be less than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or CVS Caremark for dispensing Covered Services. Where the uniform price exceeds the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or CVS Caremark for dispensing Covered Services, Aetna realizes a positive margin. In cases where the uniform price is lower than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or CVS Caremark for dispensing Covered Services, Aetna realizes a negative margin. Overall, lock-in pricing arrangements result in a positive margin for Aetna. Such margin is retained by Aetna in addition to any other fees, charges or other amounts agreed upon by Aetna and the Customer, as compensation for the pharmacy benefit management services Aetna provides to the Customer. Also, when Aetna receives payment from the Customer before payment to a Participating Pharmacy or the CVS Caremark, Aetna retains the benefit of the use of the funds between these payments.

5. The Customer acknowledges that Covered Services under a Plan may be provided by the Mail Order Pharmacy and Specialty Pharmacy. In such circumstances, the Mail Order Pharmacy and Specialty Pharmacy refer to a CVS Caremark Mail Order and Specialty Pharmacy that are licensed Participating Pharmacies. Aetna's negotiated reimbursement rates with the Mail Order Pharmacy and Specialty Pharmacy, which are the rates made available to the Customer, generally are higher than the pharmacies' cost of fulfilling orders of Prescription Drugs and Specialty Products and providing Covered Services and therefore these pharmacies realize an overall positive margin for the Covered Services they provide. To the extent the Mail Order Pharmacy and Specialty Pharmacy purchase Prescription Drugs and Specialty Products for their own account, the cost therefor takes into account both up-front and

retrospective purchase discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors. Such purchase discounts, credits and other amounts are negotiated by the Mail Order Pharmacy, Specialty Pharmacy or their affiliates for their own account and are not considered Rebates shared with Aetna by CVS Caremark in connection with Aetna's Rebate program.

6. The Customer acknowledges that Aetna generally pays Participating Pharmacies (either directly or through CVS Caremark) for Brand Drugs whose patents have expired and their Generic Drug equivalents at a single, fixed price established by Aetna (Maximum Allowable Cost or MAC). MAC pricing is designed to help promote appropriate, cost-effective dispensing by encouraging Participating Pharmacies to dispense equivalent Generic Drugs where clinically appropriate. When a Brand Drug patent expires and one or more generic alternatives first become available, the price for the Generic Drug(s) may not be significantly less than the price for the Brand Drug. Aetna reviews the drugs to determine whether to pay Participating Pharmacies (or CVS Caremark) based on MAC or continue to pay Participating Pharmacies (or CVS Caremark) on a discounted fee-for-service basis, typically a percentage discount off of the listed Average Wholesale Price of the drug (AWP Discount). This determination is based in part on a comparison under both the MAC and AWP Discount methodologies of the relative pricing of the Brand and Generic Drugs, taking into account any Rebates Aetna may receive from Prescription Drug manufacturers in connection with the Brand Drug. If Aetna determines that under AWP Discount pricing the Brand Drug is less expensive (after taking into account manufacturer Rebates Aetna receives) than the generic alternative(s), Aetna may elect not to establish a MAC price for such Prescription Drugs and continue to pay Participating Pharmacies (or CVS Caremark) according to an AWP Discount.

   In some circumstances, a decision not to establish a MAC price for a Brand Drug and its generic equivalents dispensed by Participating Pharmacies could mean that the cost of such Prescription Drugs for the Customer is not reduced. In addition, there may be some circumstances where the Customer could incur higher costs for a specific Generic Drug ordered through the Mail Order Pharmacy than if such Generic Drug were dispensed by a Participating Retail Pharmacy. These situations may result from: (i) the terms of Aetna's arrangements with Participating Pharmacies (or CVS Caremark); (ii) the amount of the Cost Share; (iii) reduced retail prices and/or discounts offered by Participating Pharmacies to Plan Participants; and (iv) the amount, if any, of Rebates to which the Customer is entitled under the Schedule and the Pharmacy Fee Schedule.

VII. AUDIT RIGHTS

1. General Pharmacy Audit Terms and Conditions

a. Subject to the terms and conditions set forth in the Agreement and disclosures made in the Prescription Drug Service and Fee Schedule, the Customer shall be entitled to have audits performed on its behalf (hereinafter "**Pharmacy Audits**") to verify that Aetna has (a) processed Claims submitted by participating pharmacies or a pharmacy benefits manager under contract with Aetna, (b) paid Rebates in accordance with this Schedule and the Prescription Drug Service and Fee Schedule. Pharmacy Audits may be performed at Aetna's Minnetonka, MN or Hartford, CT location.

b. Additional Terms and Conditions

   (i) Auditor Qualifications and Requirements specific to Pharmacy Audits

All Pharmacy Audits shall be performed solely by third party auditors meeting the qualifications and requirements of the Agreement, this Schedule and the Prescription Drug Service and Fee Schedule. In addition, the requirements set forth in section 11, Audit Rights of the Agreement, the auditor chosen by the Customer must be mutually agreeable to both the Customer and Aetna. Auditors may not be compensated on the basis of a contingency fee or a percentage of overpayments identified, in accordance with the provisions of Section 8.207 through 8.209 of the International Federation of Accountant's (IFAC) Code of Ethics for Professional Accountants (Revised 2004).

(ii) Auditor Qualifications and Requirements specific to Rebate Audits

Any audit of CVS Caremark's agreements with pharmaceutical manufacturers will be conducted by (a) one of the major public accounting firms (currently the "Big 4") approved by Aetna whose audit department is a separate stand-alone function of its business, or (b) a national CPA firm approved by Aetna whose audit department is a separate stand-alone function of its business, or (c) a mutually agreeable independent third party retained by Client.

(iii) Closing Meeting

In the event that Aetna and the Customer's auditors are unable to resolve any such disagreement regarding draft Pharmacy Audit findings, either Aetna or the Customer shall have the right to refer such dispute to an independent third-party auditor meeting the requirements of the Agreement, this section VII and the Prescription Drug Service and Fee Schedule and selected by mutual agreement of Aetna and the Customer. The parties shall bear equally the fees and charges of any such independent third-party auditor, provided however that if such auditor determines that Aetna or the Customer's auditor is correct, the non-prevailing party shall bear all fees and charges of such auditor. The determination by any such independent third-party auditor shall be final and binding upon the parties, absent manifest error, and shall be reflected in the final Pharmacy Audit report.

2. Additional Claim and Rebate Audit Terms and Conditions

a. Rebate Audits

Subject to the terms and limitations of this Schedule, the Agreement, and the Prescription Drug Service and Fee Schedule including without limitation the general Pharmacy Audit terms and conditions set forth in this section VII, the Customer shall be entitled to audit Aetna's calculation of Rebates received by the Customer as set forth below. Aetna will share the relevant portions of the applicable formulary rebate contracts, including the manufacturer names, drug names and rebate percentages for the drugs being audited. The drugs to be audited will be selected by mutual agreement of the parties. The parties will reasonably cooperate to select drugs for each audit that (a) represent the fewest unique manufacturer rebate contracts required for audit so that the selected drugs represent a maximum of [redacted] of the Customer's Rebates; which are attributable to the drugs most highly utilized by Plan Participants (b) shall be limited to (two) 2 consecutive quarters and (c) are subject to manufacturer rebate agreements that do not contain restrictions prohibiting Aetna from disclosing to the Customer portions of such contracts concerning the rebates, payments or fees payable there under. Aetna will also provide access to all documents

reasonably necessary to verify that Rebates have been invoiced, calculated, and paid by Aetna in accordance with this Schedule. The Customer is entitled to only one annual Rebate audit. Prior to the commencement of such audit, the Customer and auditor shall enter into a rebate audit confidentiality agreement acceptable to Aetna.

b. Pharmacy Claim Audits

Claim audits are subject to the above referenced audit standards for Rebates in the case of a physical, on-site, Claim-based audit. In the case of electronic Claim audits that follow standard pharmacy benefit audit practices where electronic re-adjudication of Claims is requested and processed off-site, the Customer may elect to audit [redacted] claims. The Customer is entitled to only one (1) annual Claim audit.

PHARMACY ADDENDUM
MSA – 141890
EFFECTIVE JANUARY 1, 2021

[redacted]

RETAIL

[redacted]

MAIL ORDER PHARMACY/MAINTENANCE CHOICE

[redacted]

AETNA SPECIALTY PHARMACY

[redacted]

ALLOWANCES

[redacted]

COMMISSIONS/PRODUCER COMPENSATION

[redacted]

Rebates

REBATES

[redacted]

Terms & Conditions

The pricing and services set forth herein are subject to the following Terms & Conditions:

- To the extent the pricing and services outlined in this document are part of a proposal to the Customer, the pricing set forth herein is valid for ninety (90) days from the date of such offer.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Prescriptions dispensed by a Participating Retail Pharmacy shall be processed at the lower of the pharmacy's submitted Usual & Customary Retail Price, MAC (where applicable) plus a Dispensing Fee, or discounted AWP cost plus a Dispensing Fee.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
    - Pricing guarantees are measured and reconciled as four separate components with the components defined as retail network, mail pharmacy, specialty pharmacy and Rebates.
    - Discount guarantees shall be reconciled, reported, and paid to Customer within ninety (90) days following the guarantee period.
    - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant copay and include zero balance due claims.

- The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein: compound drug claims, Exclusive Distribution and limited distribution drug (LDD) Claims, direct Plan Participant reimbursement / out-of-network claims, over-the-counter products, in-house pharmacy claims, and vaccines. In addition, we do not identify or administer any claims for 340B.
- Retail pricing guarantees include claims that reflect the Usual & Customary Retail Price.
- Single Source Generic Drugs are included in the Generic Discount guarantees.
- Prescriptions dispensed by Aetna Specialty Pharmacy are included in the Aetna Specialty Pharmacy Discount guarantee listed above.
- Aetna has assumed [redacted] in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.

- Pricing and terms in this proposal assume the Customer has elected the Aetna Standard Formulary.
- Our financial offer does not assume any adoption of the Livongo Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.
- The proposed formulary includes certain preferred Brand Drugs where the Tier 1 cost share shall be assessed to Members.
- Aetna Performance Specialty Network means that Plan Participants are required to use the Aetna Specialty Pharmacy (no fills at retail allowed).
- The Specialty Overall Effective Discount (OED) offer is conditioned on (i) Aetna being the exclusive provider of Specialty Services. The Overall Effective Discount (OED) rate will apply to all Specialty drugs on the Specialty List dispensed from a Aetna Specialty owned or affiliated pharmacy, and with the exception of:
  - New to market Specialty Brand drugs will be priced at AWP - [redacted]
  - New to market limited distribution drugs will be priced at AWP - [redacted]
  - New to market biosimilars will priced at AWP – [redacted]
    - New to market specialty drugs are defined as new drug launches, including but not limited to biologics and other products that meet the criteria included in Caremark's Specialty Drug definition. Applicable new to market drug pricing will be updated and reviewed 180 days following the drug's release to the market and during a pricing event (i.e. market check, renewal). An updated specialty fee schedule will be provided in October of each contract year that will go into effect January 1st of the following year.
- Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims may be shared with Customer in accordance with the Rebate terms described herein.
- Rebate guarantees may be subject to:
  - Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.

- [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
  - [redacted]
- Rebate guarantees assume alignment with proposed formulary, including utilization management programs to support formulary strategy, and standard prior authorization/utilization management criteria.
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty Rebate guarantees apply to specialty drug claims at all channels.
- To receive the rebate guarantees noted above:
  - Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a [redacted]-payment differential between preferred and non-preferred Brand Drugs, at least a [redacted]) differential in the minimum co-payment for coinsurance, or a differential of coinsurance [redacted] points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was [redacted], non-preferred brand would need to be [redacted] to qualify).
- Rebate guarantees are measured individually by component and reconciled in the aggregate on an annual basis within two hundred seventy (270) days; a surplus in one (1) or more component Rebate guarantees may be used to offset shortages in other component Rebate guarantees.

Consultant Compensation

Pharmacy pricing includes a one-time payment of [redacted] for the PBM RFP Fee. Eligible compensation recipients must have a valid license, if applicable, and a valid broker of record letter presented by the plan sponsor on plan sponsor letterhead with appropriate signature. Payment will be sent within thirty (30) days of receipt of invoice. Aetna to remit in 2020, assuming contract is executed prior to 2021.

Market Check

On an annual basis, during the second quarter of the second contract year, and at Client's reasonable request, Aetna or a mutually agreed upon third party with a signed non-disclosure agreement may review the financial terms of Client compared to financial offering presented to similar employers in the marketplace as deemed appropriate. The parties agree for the purpose of this market check that Aetna or Customer's representative will compare, among other things, the following factors to determine whether Client is entitled to such revised pricing terms: (i) the aggregate pricing terms of such applicable clients of comparable size, inclusive of the program savings, the retail pricing for brand and generic drugs, pricing for specialty drugs, administrative fees, Rebates and guarantees; (ii) the services provided by Aetna to such clients; and (iii) the plan design of such clients, which may include plan formulary, brand/generic utilization information and mail and retail utilization

information, available to Aetna. If Client and Aetna agree to any revisions to the financial terms as a result of this review (i) the agreement shall be amended and (ii) shall be effective January 1 of the contract year following agreement on such revisions, provided that the parties agree on final pricing not less than one hundred twenty (120) days prior to the first day of the contract year as to which the revisions are to apply. A legal document must be signed by Client and returned to Aetna ninety (90) days prior to pricing effective date.

Additional Disclosures

The Customer acknowledges that the Retail Discounts and Dispensing Fees contained in this Agreement reflect a Traditional or Lock-In pricing arrangement. Traditional or Lock-In Pricing means that the amount charged to the Customer and Plan Participants for retail network claims may differ from the amount paid to Participating Retail Pharmacy and/or Aetna's PBM subcontractor and Aetna retains the difference, in addition to any other fees or charges agreed upon by Aetna and Customer, as compensation for the pharmacy benefit management services provided to the Customer.

Aetna reserves the right to make appropriate changes to these price points if any event materially impacts Aetna's net income derived under this Agreement. Such events include (i) the termination or material modification of any material manufacturer Rebate contract, (ii) any significant changes in the composition of Aetna's pharmacy network or in Aetna's pharmacy network contract compensation rates with its pharmacy network subcontractor, CVS Health, (iii) a change in government laws or regulations, (iv) a change in the Plan that is initiated by Customer, (v) AWP is discontinued or modified in whole or in part, or (vi) a greater than [redacted] change in enrollment or a material change, as defined by Aetna, in the drug utilization, plan design, geographic mix or demographic mix of the covered population from what was assumed at the time of underwriting. Aetna shall provide the Customer with at least sixty (60) days written notice of such changes together with a sufficiently detailed explanation supporting these price point changes. If sixty (60) days written notice is not practicable under the circumstances, Aetna shall provide written notice as soon as practicable.

Aetna reserves the right to modify its products, services, and fees, and to recoup any costs, taxes, fees, or assessments, in response to legislation, regulation or requests of government authorities. Any taxes or fees (assessments) applied to self-funded benefit Plans related to The Patient Protection and Affordable Care Act (PPACA) will be solely the obligation of the Plan sponsor. The pharmacy pricing contained herein does not include any such Plan sponsor liability.

Rebate Payment Terms

Rebates will be distributed on a quarterly basis by claim wire credit. Rebate allocations will be made within [redacted], with payments issued to customers in the month following allocation. Rebates are paid on Prescription Drugs dispensed by Participating Pharmacies and covered under Customer's Plan. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer Rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. The Customer shall adopt the formulary indicated in the Rebates section of this Service and Fee Schedule in order to be eligible to receive Rebates.

The Rebate schedule will be as follows:

- [redacted]

- [redacted]

If this Agreement is terminated by Aetna for the Customer's failure to meet its obligations to fund benefits or pay administrative fees (medical or pharmacy) under the Agreement, Aetna shall be entitled to deduct deferred administrative fees or other plan expenses from any future Rebate payments due to the Customer following the termination date.

Formulary Management

Aetna offers several versions of formulary options ("Formulary") for Customer to consider and adopt as Customer's Formulary. The formulary options made available to Customer will be determined and communicated by Aetna prior to the implementation date. Customer agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted Customer the right to use one of its Formulary options during the term of the Agreement solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. As such, Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the Plan. Customer further understands and agrees that from time to time Aetna may propose modifications to the drugs and supplies included on the Formulary as a result of factors, including but not limited to, market conditions, clinical information, cost, Rebates and other factors. Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

Other Payments

The term "Rebates" as defined in the Prescription Drug Services Schedule does not include manufacturer administrative fees that may be paid by pharmaceutical manufacturers to cover the costs related to the reporting and administration of the pharmaceutical manufacturer agreements. Such manufacturer administrative fees are not shared with Customer hereunder.

Aetna may also receive other payments from drug manufacturers and other organizations that are not Rebates. These payments are generally for one of two purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data or (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and members about clinical guidelines, disease management and other effective therapies. These payments are not considered Rebates and are not included in Rebate sharing arrangements with plan sponsors, including without limitation, Customer.

Aetna's PBM subcontractor may also receive network transmission fees from its network pharmacies for services it provides for them. These amounts are not considered Rebates and are not shared with plan sponsors. These amounts are also not considered part of the calculation of claims expense for purposes of Discount Guarantees.

Customer agrees that the amounts described above are not compensation for services provided under this Agreement by either Aetna or Aetna's PBM subcontractor, and instead are received by Aetna in connection with

network contracting, provider education and other activities Aetna conducts across its book of business. Customer further agrees that the amounts described above belong exclusively to Aetna or Aetna's PBM subcontractor, and Customer has no right to, or legal interest in, any portion of the aforesaid amounts received by Aetna or Aetna's PBM subcontractor.

Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit [redacted]. Payments or rebates from drug manufacturers that compensate Aetna for the cost of developing and administering value-based Rebate contracting arrangements when drug therapies underperform thereunder also will be retained by Aetna.

Early Termination
Subject to the terms of the Agreement, either party may terminate the Agreement without cause, any time after one (1) year, with ninety (90) days prior written notice. In the event Client terminates the Agreement prior to the expiration of the initial term for any reason other than for Aetna's material breach, Client shall refund, prior to the termination date, to Aetna all implementation credits and PBM services credits for the unfulfilled term on a prorated basis, which the parties agree are liquidated damages and shall not be characterized as a penalty (collectively, the "Termination Fee"). Unless otherwise agreed in writing by the parties, such Termination Fee will be due and paid in full within sixty (60) days after the termination effective date.

Pharmacy Audit Rights and Limitations
Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the pharmacy services schedule.
Pharmacy audits shall be conducted at the Customer's own expense unless otherwise agreed to between the Customer and Aetna.

If this Agreement is terminated by Aetna for the Customer's failure to meet its obligations to fund benefits or pay administrative fees (medical or pharmacy) under the Agreement, Aetna shall be entitled to deduct deferred administrative fees or other plan expenses from any future Rebate payments due to the Customer following the termination date.

PHARMACY PERFORMANCE GUARANTEES ADDENDUM
MSA – 141890
EFFECTIVE JANUARY 1, 2021

General Performance Guarantee Provisions

Aetna Life Insurance Company (ALIC) provides benefits administration and other services for the self-funded pharmacy plans. The services set forth in this document will be provided by ALIC (hereinafter "Aetna").

Performance Objectives

Aetna believes that measuring the activities described below are important indicators of how well we service Affiliated Physicians and Employer's Master Trust. We are confident that pharmacy administration services provided to Affiliated Physicians and Employer's Master Trust will meet their high standards of performance. To reinforce Affiliated Physicians and Employer's Master Trust's confidence in Aetna's ability to administer their program, we are offering guarantees in the following areas:

Performance Guarantee Category	Minimum Standard	Proposed Penalty
[redacted]		

Performance Guarantee Category	Minimum Standard	Proposed Penalty
[redacted]		

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **January 1, 2021 through December 31, 2021** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the self-funded Aetna Pharmacy Management plans administered under the Administrative Services Only Agreement ("Services Agreement"). These guarantees do not apply to non-Aetna benefits or networks.

Aggregate Maximum

In total, Aetna agrees to place [redacted] at risk through the Performance Guarantees outlined in this document. Aetna reserves the right to revisit the guarantees if there is a change in enrollment of more than [redacted] Affiliated Physicians and Employer's Master Trust can re-allocate up to [redacted] on any one guarantee [redacted] of Ongoing Maximum at Risk). Aetna shall provide the performance guarantee report card no later than ninety (90) days after the end of the applicable calendar year. Should the report card fall due on a non-business day, the report card will be provided on the first business day following the due date.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by Aetna in the event of the occurrence of (i), (ii) or (iii) below:

i. a material change in the plan initiated by Affiliated Physicians and Employer's Master Trust or by legislative action that impacts the claim adjudication process, member service functions, pharmacy network management or rebates;
ii. failure of Affiliated Physicians and Employer's Master Trust to meet its obligations to remit administrative service fees or fund the Affiliated Physicians and Employer's Master Trust bank account as stipulated in the General Conditions Addendum of the Services Agreement;
iii. failure of Affiliated Physicians and Employer's Master Trust to meet their administrative responsibilities (e.g., a submission of incorrect or incomplete eligibility information).

No guarantees shall apply for a guarantee period during which the Services Agreement is terminated by Affiliated Physicians and Employer's Master Trust or by Aetna.

Penalty Reconciliation and Refund Process

At the end of each guarantee period, Aetna will compile the Performance Guarantees results. If necessary, Aetna will provide a refund to Affiliated Physicians and Employer's Master Trust for any penalties incurred.

Implementation

Implementation Guarantee

Guarantee: Aetna developed and utilizes the implementation team concept to carefully coordinate all aspects of the implementation. An implementation manager will be assigned to assemble Affiliated Physicians and Employer's Master Trust's implementation team and working with Affiliated Physicians and Employer's Master Trust's team, will help determine the implementation priorities. The implementation manager will develop an implementation management plan that will outline the tasks to be accomplished and will also indicate mutually agreed upon target dates for their completion. As new information becomes available and priorities change, the plan will be updated. Affiliated Physicians and Employer's Master Trust will be responsible for providing key information to Aetna by the mutually agreed upon target dates. The performance guarantee is contingent upon Affiliated Physicians and Employer's Master Trust's required participation in reviewing Aetna's plan of benefits detail document.

Aetna is confident that Affiliated Physicians and Employer's Master Trust will be pleased with our implementation team approach and therefore we are offering an implementation performance guarantee. This guarantee is effective for the implementation period in the first guarantee period. The implementation period commences at the initial implementation meeting and runs through the implementation sign-off.

Penalty and Measurement Criteria: Within 45 days following the effective date via timely responses to the Implementation Evaluation Tool, Affiliated Physicians and Employer's Master Trust agrees to make Aetna aware of possible sources of dissatisfaction throughout the implementation period. Each question will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. Results from the evaluation tool when will be used to facilitate a discussion between Affiliated Physicians and Employer's Master Trust, the implementation manager and the Pharmacy Account Team regarding the results achieved. If, at the end of the implementation process, the final average score of the evaluations [redacted] a mutually agreed upon penalty will apply, subject to a maximum penalty of [redacted] The guarantee will be considered met if the survey is not returned.

Account Management

Overall Pharmacy Account Management Guarantee

Guarantee: Aetna guarantees that the services (i.e., on-going financial, eligibility, drafting, and benefit administration and continued customer support) provided by the Pharmacy Account Team during the guarantee period will be satisfactory to Affiliated Physicians and Employer's Master Trust.

Penalty and Measurement Criteria: Via quarterly responses to this link, http://www.aetnasurveys.com/se.ashx?s=103ED34467D2D0E0, Affiliated Physicians and Employer's Master Trust agrees to make Aetna aware of possible sources of dissatisfaction throughout the guarantee period. Affiliated Physicians and Employer's Master Trust's responses to the evaluation tool will evaluate account management services in the following categories: technical knowledge, accessibility of personnel, responsiveness of personnel, interpersonal skills, communication skills (written and oral) and overall assessment of the services provided to Affiliated Physicians and Employer's Master Trust. Overall satisfaction ratings of at least [redacted] on a 5-point scale (5 is best rating) shall be guaranteed with 100% participation. For the purposes of this guarantee, satisfaction shall be defined as [redacted] on the following 5-point scale; Excellent, Very Good, Good, Fair, Poor. Aetna shall be responsible for survey design, data collection, analysis and all costs associated with conducting the surveys.

If the report cards are not completed and returned within 15 days after the end of the quarter it will be assumed that the service provided to Affiliated Physicians and Employer's Master Trust is satisfactory, and the score for the period covered by the report card not returned shall be designated as an [redacted] on a scale of 1 to 5. If the score on the first report card and the report card(s) for the subsequent survey(s) average a [redacted] or higher, no credit is due. Satisfactory service would equal a score of [redacted] and would be based on the total average of 24 questions with a rating scale of 1 to 5. Should the score from the first report card and the average of the remaining report card(s) fall below a [redacted] (meaning that service levels have not improved), a mutually agreed upon penalty will apply, subject to a maximum penalty of [redacted]

In Person Meetings

Guarantee: Four (4) in person meetings with AFFILIATED PHYSICIANS annually, and up to weekly calls via phone (at AFFILIATED PHYSICIANS's discretion). Additionally, meeting materials delivered electronically to the AFFILIATED PHYSICIANS at least three (3) business days in advance of the meeting, and will follow-up on all open issues within three (3) business days after the meeting.

Penalty and Measurement Criteria: A penalty of [redacted] apply if PBM fails to four (4) in person meetings with AFFILIATED PHYSICIANS annually, and up to weekly calls via phone (at AFFILIATED PHYSICIANS's discretion). Additionally, meeting materials delivered electronically to the AFFILIATED PHYSICIANS at least three (3) business days in advance of the meeting, and will follow-up on all open issues within three (3) business days after the meeting.

Account Management Inquiries and Issues

Guarantee: PBM will guarantee that all inquiries and issues sent the Account Management team will be responded to within 1 business day. For inquiries and issues that cannot be resolved within 1 business day, the Account Team will add them to an issue tracking log and provide an update on weekly call (or more frequently via email is at AFFILIATED PHYSICIANS request). Updates will be made at least every 7 calendar days."

Penalty and Measurement Criteria: A penalty of [redacted] will apply if PBM fails to respond to inquiries and issues sent the Account Management team within 1 business day. For inquiries and issues that cannot be resolved within 1 business day, the Account Team will add them to an issue tracking log and provide an update on weekly call (or more frequently via email is at AFFILIATED PHYSICIANS request). Updates will be made at least every 7 calendar days.

Quarterly Pharmacy Utilization Reports Guarantee

Guarantee: Aetna guarantees on-line Quarterly Pharmacy Utilization Managements Reports will be made available to Affiliated Physicians and Employer's Master Trust within 45 days after the end of a calendar quarter.

Definition: Quarterly Pharmacy Utilization Management Reports will be available through Aetna's website within 30 days after the end of the calendar quarter. Reports can be easily downloaded into Microsoft Excel for data manipulation, graphing and communication.

Penalty and Measurement Criteria: A penalty of [redacted] will apply for each quarter that the reports are not provided within 30 days after the end of the calendar quarter. There will be a maximum penalty of [redacted] Aetna's records will be used to determine if the terms of this guarantee have been met.

Plan Sponsor Services

Eligibility Updates Guarantee

Guarantee: Aetna guarantees that based on receipt of a clean, accurate and complete electronic eligibility file no later than the 5th day of the month that is prior to the effective date of the Agreement or mutually agreed upon re-issue date, that [redacted] of enrollees to Aetna will be mailed ID cards and/or Welcome Booklets 10 days prior to the effective date or re-issue date. This is measured on a APEMT specific basis.

Definition: Complete enrollment/eligibility data is defined as employee name, address, provider selection, DOB, SSN, and covered dependent information if applicable as well as mutually agreed upon eligibility specifications. This information will be submitted electronically, by magnetic tape, or by cartridge. The guarantee is contingent upon the file being transmitted successfully to Aetna (files received after 12:00 Noon will be considered as having been received on the next business day). Any eligibility data received which must be adjusted by Aetna using a tape fix will negate the guarantee and normally adds 72 hours to the entire process. Depending on the eligibility submission method, the following reports will be used to determine the completeness of the data provided by Affiliated Physicians and Employer's Master Trust: Audit Certificate List, ELR Report, and Transaction Audit Report. Errors caused by the lack of complete data will be excluded from the terms of this guarantee.

Penalty and Measurement Criteria: A penalty of [redacted] will apply for each day that the eligibility submissions are not processed. There will be a maximum penalty of [redacted] Aetna's results will be used to determine whether the terms of the guarantee have been met.

Plan Administration Accuracy Guarantee

Guarantee: Aetna guarantees to mail member notification of negative formulary changes at least thirty (30) days prior to the effective date of such change for those who have adopted an Aetna standard formulary and opted in to have us execute these notifications. Aetna shall be exempt from this guarantee in the event of a critical launch or receipt of retroactive notice.

Penalty and Measurement Criteria: A penalty of [redacted] will apply if Aetna fails to mail member notification of negative formulary changes at least thirty (30) days prior to the effective date of such change for those who have adopted an Aetna standard formulary and opted in to have us execute these notifications

Retail Claim Administration

Turnaround Time – Paper Claims Guarantee

Guarantee: Aetna guarantees that the claim payment processing turnaround time for all retail pharmacy claims submitted on paper will be [redacted] within a weighted average of 5 business days of receipt and [redacted] within a weighted average of 10 business days of receipt.

Definition: Total percentage of claims processed is measured as the number of claims processed within specified number of days divided by the total number of claims audited. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of [redacted] apply for each [redacted] that the actual turnaround time for reimbursement of paper claims submitted falls below the guaranteed level of [redacted] within a weighted average of 5 business days of receipt and [redacted] within a weighted average of 10 business days of receipt. There will be a maximum penalty of [redacted] Guarantee results will be measured based on Aetna's book of business.

Mail Order Claim Administration

Turnaround Time - Clean Claims Guarantee

Guarantee: Aetna guarantees that at least [redacted] of all mail order claims not requiring intervention will be dispensed and shipped within an average of 2 business days of receipt.

Definition: For the respective guarantee period, turnaround time for claims, not requiring intervention is determined by assessing the average time, in business days, that it takes prescriptions to be processed and shipped from the Aetna Rx Home Delivery pharmacy. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of [redacted] will apply for each full day that the average turnaround time of [redacted] all mail order claims not requiring intervention exceeds an average of 2 business days. There will be a maximum penalty of [redacted] Guarantee results will be measured based on Aetna's book of business.

Turnaround Time – Claims Requiring Intervention Guarantee

Guarantee: Aetna guarantees that at least [redacted] of all mail order claims requiring intervention will be dispensed and shipped within an average of 5 business days of receipt.

Definition: For the respective guarantee period, turnaround time for claims, requiring intervention is determined by assessing the average time, in business days, that it takes prescriptions to be processed and shipped from the Aetna Rx Home Delivery pharmacy. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of [redacted] will apply for each full day that the average turnaround time of [redacted] of all mail order claims requiring intervention exceeds an average of 5 business days. There will be a maximum penalty of [redacted] Guarantee results will be measured based on Aetna's book of business.

Member Services

Average Speed of Answer

Guarantee: Aetna guarantees that the average speed of answer for the phone skill(s) providing Affiliated Physicians and Employer's Master Trust's member services will not exceed 30 seconds.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average speed of answer. Average speed of answer is defined as the amount of time that elapses between the time a call is received into the telephone system and the time a representative responds to the call. The result expresses the sum of all waiting times for all calls answered by the queue divided by the number of incoming calls answered. ASA measures the average speed of answer for all callers answered. Interactive Voice Response (IVR) system calls are not included in the measurement of ASA. In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of [redacted] will apply for each full second that the average speed of answer exceeds 30 seconds. There will be a maximum penalty of [redacted] Aetna's results for the unit(s) providing member services for Affiliated Physicians and Employer's Master Trust will be used.

Pharmacy First Call Resolution Guarantee

Guarantee: Aetna guarantees that [redacted] of member service calls with be successfully resolved on the first call. Resolution shall be deemed successfully resolved if there are no handoffs via resolution manager.

Definition: On an annual basis, Aetna will share with Affiliated Physicians and Employer's Master Trust the First Call Resolution results. The rate will be calculated based upon first calls where the issue was within Aetna's control to resolve and there were no handoffs via resolution manager.

Penalty and Measurement Criteria: A penalty of [redacted] will apply for each [redacted] that the First Call Resolution rate falls below [redacted]. There will be a maximum penalty of [redacted] Aetna's results for the unit(s) providing member services for Affiliated Physicians and Employer's Master Trust will be used.

TAT Response of Internet Inquiries Guarantee

Guarantee: Aetna guarantees to provide an initial response rate to [redacted] of email inquiries within 24 hours and provide a resolution to [redacted] of email inquiries within 48 hours.

Definition: Aetna measures from the date the email inquiry is received by PBM from the member until date/time PBM sends its response that acknowledges the members issue. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of [redacted] will apply for each [redacted] that the TAT response of internet inquires falls below providing an initial response to [redacted] of email inquiries within 24 hours and provide a resolution to [redacted] of email inquiries within 48 hours. There will be a maximum penalty of [redacted] Guarantee results will be measured based on Aetna's book of business.

Member Satisfaction Guarantee

Definition: Aetna guarantees an [redacted] or better member satisfaction rate.

Penalty and Measurement Criteria: Aetna will reduce its compensation by [redacted] if it fails to meet a response rate of [redacted] or better. Member Call Center survey results will be used as the basis of the measurement criteria.

Annual Plan Benefit Review Guarantee

Guarantee: PBM will conduct an annual benefit plan review 45 days prior to effective date of any plan benefit changes, i.e. copayments, co-insurance, clinical rules, etc.
Provided APEMT submits benefit design changes at least 60 days prior to the effective date.

Penalty and Measurement Criteria: A penalty of [redacted] will apply if PBM fails to conduct an annual benefit plan review 45 days prior to effective date of any plan benefit changes, i.e. copayments, co-insurance, clinical rules, etc. Provided APEMT submits benefit design changes at least 60 days prior to the effective date.

Prior Approval for specific drugs Guarantee

Guarantee: PBM will promptly review and respond to requests for prior approval for specific drugs following receipt of all required information. PBM will guarantee a response no later than within 2 business days. Aetna will promptly review and respond to request for prior authorization approval for specific drugs following receipt of all required information, but in any case will respond to [redacted] of requests in no more than two (2) Business Days.

Penalty and Measurement Criteria: A penalty of [redacted] will apply if PBM fails to promptly review and respond to requests for prior approval for specific drugs following receipt of all required information within 2 business days.

Quarterly Reports Guarantee

Guarantee: PBM will guarantee that each quarterly report will be provided to the client 5 business days prior to the meeting. The reports included in the measurement of this guarantee shall be mutually agreed upon award of the business.

Penalty and Measurement Criteria: A penalty of [redacted] will apply if PBM fails to provide each quarterly report to the client within 5 business days prior to the meeting. The reports included in the measurement of this guarantee shall be mutually agreed upon award of the business.